Medical Contracts

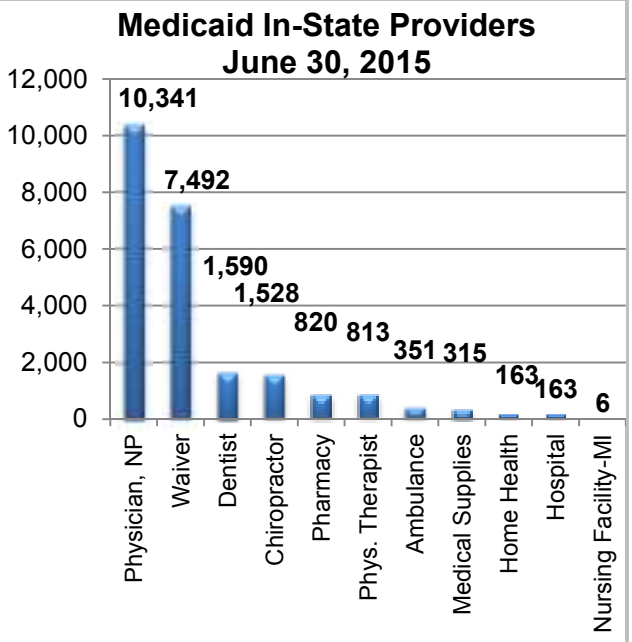
Purpose

The Medicaid Program's administration will shift in SFY16 from one of a largely fee-for-service based population to a Medicaid population managed by multiple managed care organizations (MCOs). IME is also responsible for oversight of the MCO contracts through which services are administered to the Iowa Medicaid and hawk-i populations. The shift resulted in the Iowa Medicaid Enterprise (IME) transitioning from an operational focus to an MCO oversight focus. However, IME still performs all of the required fee-for-service functions on a much smaller scale.

A small percentage of Medicaid fee-for-service for designated populations and initially for new enrollees remains in SFY17 and into the future. These operations and oversight functions are performed through a staff of 47 full time state employees (including 12 Health Insurance Premium Payment (HIPP) staff) and nine performance based contracts with private vendors that have seen their original contracts reduced in scope and, in some cases, re-focused to oversight of MCO data and reports. Some vendors will continue to carry out required fee-for-service functions including the processing of claims, enrolling providers and members and pursuing cost recovery.

Who Is Helped

- The IME contracts with vendors to administer the Medicaid program. These administrative costs are funded through the Medical Contracts appropriation.
- Medicaid enrolls the same private and public providers as other insurers in Iowa and is the second largest health care payor in Iowa.

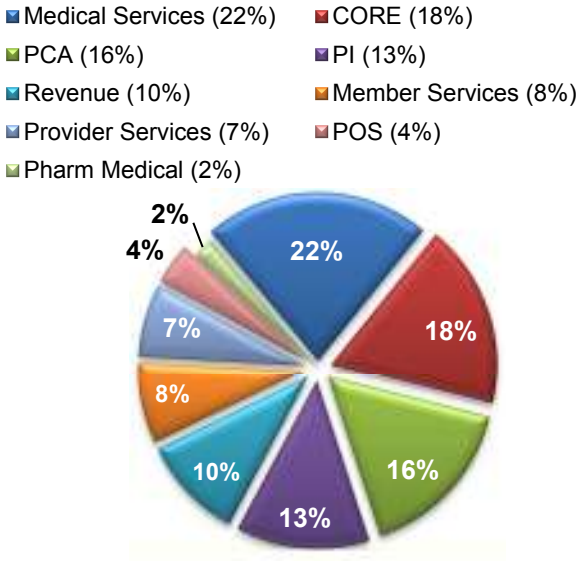


Services

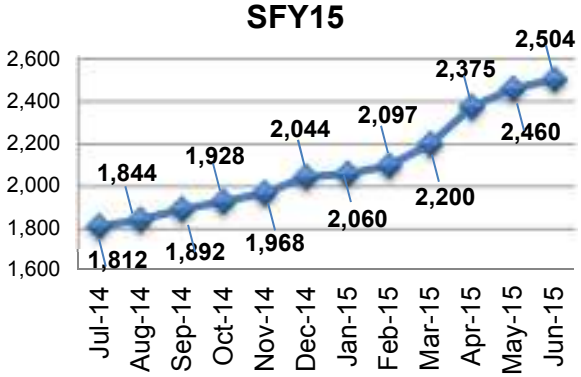
Iowa Medicaid utilizes nine performance-based contracts with vendors who provide key business services. These contracts are integrated under state oversight and management in a single location and comply with over 200 performance measures to achieve maximum value for Iowa taxpayers. The IME vendors carry out the following primary functions, but at a significantly reduced level from pre-MCO implementation:

- **CORE Services** include mailroom operations, claims processing and operation of systems, including the Medicaid Management Information System (MMIS).
- **Medical Services** provides a variety of utilization management and quality management activities
- **Member Services** provides customer service, assists members as an enrollment broker in selection of an MCO.
- **Pharmacy Medical Services** maintains the Preferred Drug List (PDL), and responds to inquiries to the pharmacy prior authorization hotline.
- **Pharmacy Point of Sale (POS)** collects drug rebates from manufacturers, answers questions and resolves fee-for-service claim issues for pharmacies.
- **Provider Cost Audit (PCA)** provides technical assistance to providers, performs rate setting, cost settlement, cost audit functions and ensures that payments made to Medicaid providers are in accordance with state and federal requirements.
- **Program Integrity (PI)** efforts include identifying potential fraud, waste and abuse.
- **Provider Services** supports providers who deliver services to Medicaid members. Functions include provider enrollment and certification, and education and outreach activities.

SFY16 Projected Share of State Expenditures by IME Units

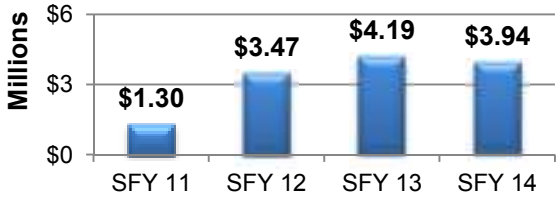


Lock-In Monthly Enrollment SFY15



Lock-In and Medical Health Education Savings

Disease Management Savings



- **Revenue Collections** functions include; Third Party Liability (TPL) for cost avoidance to ensure that Iowa Medicaid is the payer of last resort for fee-for-service claims, recovery of funds where Medicaid has paid prior to a responsible third party, and estate recovery to obtain repayment of Medicaid expenditures from estates of members who are age 55 and over, or lived in a medical facility.

- Medical Contracts includes a number of additional contracts and vendors who all contribute to the administration of the Medicaid program.

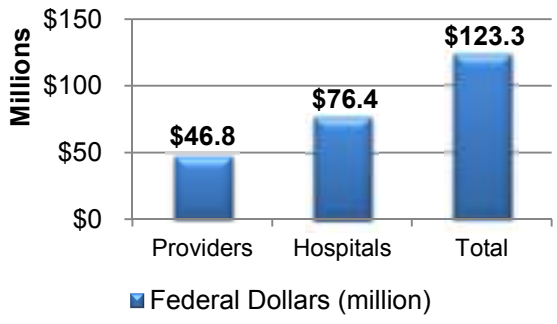
- The IME administers the Electronic Health Record (EHR) Incentive Payment program, which distributes 100 percent federal payments to hospitals, physicians and other eligible Medicaid providers for implementing EHRs and incenting meaningful use of the systems.

Preferred Drug List Savings

Program Integrity Savings

Revenue Collections

Medicaid Electronic Health Record Payments (since January, 2011)



	✓ *Medicaid processed nearly 40 million claims in SFY15. The average time from the receipt of an electronic claim form to payment was six days in SFY15.* ✓ *Program Integrity saved Medicaid $46.78 million in SFY15 through the identification of overpayments, coding errors, and fraud, waste, and abuse. The Recovery Audit contract accounted for approximately $10.7 million of the $46.78 million recovered.* ✓ *Prior authorizations for HCBS saved over $3.4 million in SFY15.*
Goals & Strategies	Effectively Manage Resources: • Implementation of the Preferred Drug List (PDL) dramatically reduced the per user per year prescription drug cost from over a pre-rebate cost of $804.79 to post-rebate cost of $369.20 per user per year during SFY14. The PDL is projected to save over $84.3 million in SFY16. • Increase Medicaid provider performance by sharing data to improve quality. • Continue and expand Program Integrity efforts in DHS programs. • Maximize federal financial participation to the greatest extent possible. • Align medical contracts to support MCO oversight.
	SFY14 Medicaid Member Satisfaction with Call Center 
	✓ *Medicaid collected over $272 million in revenue in SFY15 through cost avoidance and recovery when other insurance is present. Medicaid projects cost avoidance and recovery savings of $136 million in SFY16, $25 million in SFY17, and $25 million in SFY18.*
Legal Basis	**Federal:** • Title XIX of the Social Security Act. 42 CFR 434.1. Section 1902(a) (4) of the Act requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan. 434.1(b) sets forth the requirements for contracts with certain organizations for furnishing Medicaid services or processing or paying Medicaid claims or enhancing the agency's capability for effective administration of the program.